



MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

*Coroners Act 1995
Coroners Rules 2006
Rule 11*

I, Leigh Mackey, Coroner, having investigated the death of Shirley Dorothy Dawn Martin

Find, pursuant to Section 28(1) of the Coroners Act 1995, that

- a) The identity of the deceased is Shirley Dorothy Dawn Martin (Mrs Martin). Mrs Martin was born in New South Wales but lived and worked most of her life in Queensland with her husband. Following his death in 2000, she moved to Mackay in Queensland to live with her son, Shane, and two granddaughters, Dannielle and Josephine. She then moved to Tasmania and settled initially in Smithton and then in Hobart. In 2015 she was diagnosed with Alzheimer's Disease and due to her declining condition moved into supported residential care at Respect Aged Care Wellington View (RACF) on 5 October 2017.
- b) On 8 August 2022 Mrs Martin fell at the RACF. The fall was unwitnessed. Mrs Martin was found lying in the corridor outside her room. Prior to the fall, Mrs Martin's dementia had worsened. She was confused and agitated. Because of the fall Mrs Martin suffered a fracture of her left hip. She was transferred to the Royal Hobart Hospital (RHH) and the hip fracture was treated surgically by an open reduction and internal fixation on 9 August 2022. Post operatively Mrs Martin remained confused and refused to take her medication. She was transferred back into the care of the RACF on 19 August 2022, ten days after the surgery. She was bed ridden and remained confused and agitated. Mrs Martin died five days after her return to the RACF.
- c) Staff Specialist-Forensic Pathologist, Dr Reid has undertaken an examination of Mrs Martin, including her RHH medical records and is of the opinion that her death was caused by an exacerbation of her behavioural and psychological symptoms of dementia following the surgical repair of the hip fracture which had resulted from her fall at the RACF. I accept this opinion.
- d) Mr Martin died on 24 August 2022 at Old Beach, Tasmania.

In making the above findings, I have had regard to the evidence gained in the comprehensive investigation into Mrs Martin's death. The evidence includes:

- The Police Report of Death for the Coroner;
- Affidavits as to identity;
- Report of Dr Andrew Scott Reid, Forensic Pathologist;
- Affidavit from Mr Shane Martin;
- Letter from Mike McDermott, Director Clinical Services, Ambulance Tasmania (AT) and AT Patient Care Records for Mrs Martin;
- Medical records of Mrs Martin held by RHH and obtained from the Tasmanian Health Service (THS);
- Medical records of Mrs Martin obtained from Eastern Shore Doctors; and
- Records obtained from the RACF.

Mrs Martin's Health

Mrs Martin had been diagnosed with type II diabetes, an acute myocardial infarction,¹ congestive cardiac failure,² chronic renal (kidney) failure, osteoporosis, paroxysmal atrial fibrillation,³ polymyalgia rheumatica,⁴ hypercholesterolaemia,⁵ hypertension,⁶ osteoarthritis, vitamin D deficiency and a left pubic ramus fracture.⁷

Mrs Martin's cognitive functioning had rapidly declined in recent years following a slow decline in functioning since approximately 2015. In the months preceding 8 August 2022, it was reported that Mrs Martin had become increasingly confused and agitated with her relatives and the aged care staff which, for her, was described as uncharacteristic behaviour. Due to her ongoing cognitive decline, Mrs Martin was referred to the geriatrician Dr Jane Tolman for a cognitive/dementia assessment on 8 June 2022. On 14 June 2022, Dr Tolman concluded Mrs Martin suffered from a progressive neurodegenerative disease and likely had advanced dementia due to Alzheimer's disease. Dr Tolman considered her dementia to be reducing the quality of her life significantly and raised end-of-life matters with her granddaughter at this

¹ Permanent damage to the heart muscle due to inadequate oxygen supply caused by an obstruction of the coronary artery; i.e. a heart attack.

² This condition occurs when the heart muscle doesn't pump blood as well as it should. Blood often backs up and causes fluid to build up in the lungs and in the legs. The fluid build-up can cause shortness of breath and swelling of the legs and feet.

³ Paroxysmal atrial fibrillation occurs when a rapid, erratic heart rate begins suddenly and then stops on its own within seven days.

⁴ An inflammatory disorder that causes muscle pain and stiffness, especially in the shoulders and hips.

⁵ Elevated levels of cholesterol in the blood.

⁶ High blood pressure.

⁷ Fracture of the pelvis.

time.

Circumstances Leading to Mrs Martin's Death

Whilst a resident at the RACF, Mrs Martin was known to walk regularly around the facility to attend activities and to sit outside. She mobilised with the aid of a four wheeled walker (4WW). She was, in accordance with the protocols operating at the RACF, regularly reviewed for her falls risk. Prior to 8 August 2022, Mrs Martin had last fallen at the RACF on 15 September 2020.

At approximately 1.00am on 8 August 2022, staff found Mrs Martin awake in her room. They reported that she was agitated and confused, believing it was already morning and wanting to shower. They encouraged her to return to bed. She declined and instead settled in her recliner chair. At approximately 3.00am, staff found Mrs Martin lying on the floor in the hallway outside her room. She was on her left-hand side, distressed and in pain.⁸ There was a skin tear on her right thumb, and she voiced discomfort and pain when rotating her left hip.

At approximately 3.30am, the facility left a message with Mrs Martin's granddaughter, Josephine Martin,⁹ requesting permission to call an ambulance. The facility contacted Ambulance Tasmania (AT) at 3.34am. Ambulance Tasmania dispatched a crew at 7.26am who were with Mrs Martin at the facility by 7.45am. At 8.48am, Mrs Martin arrived at RHH by ambulance. She was allocated to a ward bed but not admitted until 4.00pm that day. RHH staff noted that she was highly confused and agitated. Dannielle Martin visited at 5.30pm and reported that Mrs Martin could tell her who she was but appeared highly distressed.

On 9 August 2022, at approximately 4.00pm, Mrs Martin was taken into surgery to repair a left intertrochanteric fracture. The surgery was uneventful. She was given a blood transfusion on 10 August 2022. While at the RHH, Mrs Martin refused to take her medication. It was noted that she was experiencing periods of hypoactive delirium throughout the length of her admission.

On 19 August 2022, Mrs Martin was released from RHH and transported to the RACF. On her return, staff reported she was confused about the time, date, and place. Mrs Martin was now bedridden and required assistance with personal care and feeding. Staff observed she was in pain upon movement during nursing interventions. Mrs Martin was not prescribed pain

⁸ Discrepancies exist between the Police Report and the Incident Report by Wellington Views. The Police Report states that Mrs Martin was found at 1.00 am on the floor not 3.00 am.

⁹ The Incident Report states a message was left with Dannielle Hall. However, Josephine Martin's number was called, and the message was left with her.

medication until 22 August 2022. Between 21 and 22 August 2022, Mrs Martin removed her catheter repeatedly. Her food intake was minimal during this time.

On 22 August 2022, Mrs Martin was assessed by geriatrician Dr Jane Tolman. After consultation with Dannielle, it was agreed that Mrs Martin should commence end-of-life care. Bedside monitoring of Mrs Martin by family began at 3.30pm on 23 August 2022. A syringe driver commenced at 9.35pm that same day. Mrs Martin slowly declined and passed away on 24 August 2022 at 11.54am.

Investigation

Following her death, Mrs Martin's son, Shane, raised concerns about:

- Whether Mrs Martin's fall could have been avoided;
- The response of staff at the RACF to Mrs Martin's fall; and
- The delay in an ambulance arriving at the RACF.

As previously noted at the time of her fall, Mrs Martin was independently mobile, using a 4WW to move around the facility, including outdoor areas. Dr Tolman notes in her assessment on 14 June 2022 that Mrs Martin mobilised independently. Since her admission at the RACF, Mrs Martin had experienced minimal falls. Minor falls were recorded on 12 November 2018 and 15 September 2020. In February 2020, Mrs Martin received an assessment on her left shoulder after falling against a fire extinguisher. She reported to the RACF staff that she saw a 'bright light' and 'force' that threw her down. An x-ray showed no dislocation. The RACF last completed a Falls and Other Risks Safety Assessment for Mrs Martin on 18 April 2022. Despite her cognitive decline, Mrs Martin's medical records do not indicate Mrs Martin's risk of falling had increased in the months preceding her death.

A review of the records of the RACF has been undertaken by Mr Egan, Forensic Medicine Coronial Nurse. In his report of 19 December 2023, he did not identify any concerns regarding the falls prevention and risk mitigation strategies utilised by the RACF for Mrs Martin. The Falls Risk Assessment current at the time of Mrs Martin's fall was appropriate for her condition as was the care she was provided at the RACF. I accept this assessment.

Whilst staff did find Mrs Martin awake in her room prior to the fall on 8 August 2022, this was not viewed as uncharacteristic or behaviour that would warrant checks outside those routinely done at the facility.

If it is accepted that facility staff found Mrs Martin after her fall at approximately 3.00am and not 1.00am, there was minimal delay in the time it took the facility to contact her next of kin or AT. Unfortunately, the facility contacted Josephine instead of Dannielle; however, this error

appears to have caused no significant delay in the time it took to contact AT. A message was left with Josephine at approximately 3.30am, and AT records indicate they received a call from the facility regarding Mrs Martin at 3.34am.

RACF records indicate that following her fall, Mrs Martin was made comfortable in bed while waiting for AT to arrive, which staff expected to be a considerable wait. Staff commenced neurological and clinical observations, and Mrs Martin was provided with one-to-one support until her care was transferred to AT at approximately 7.45am. The care provided to Mrs Martin by the RACF following her fall was appropriate and adequate.

The source of the belief that Mrs Martin fell at 1.00am is unclear. The Police Report of Death refers to the RACF staff finding Mrs Martin on the floor at “approximately 1.00am”. It is also noted that Mrs Martin had been agitated and confused in the hours leading up to her fall and had got out bed and was trying to get into the shower. The report would have necessarily been prepared based on second hand information. An incident form was completed at 11.24am on 8 August 2022 by the RACF care manager. The fall was identified in the report as having occurred at 3.00am during a routine round for hygiene care. The record further reflects interaction between Mrs Martin and RACF staff as having occurred at 1.00am when Mrs Martin was out of bed wanting to have a shower as she believed it was the morning. The version of events contained in the incident report form is also reflected in Mrs Martin’s progress notes which consistently refers to the time of the fall as being around 3.00am. It is clear from the detail and the nature of the information contained in the incident report and progress notes that the information as to when and what occurred was obtained from those involved directly in Mrs Martin’s care at the time of these events. The AT patient care report refers to the unwitnessed fall as having occurred between 11.00pm and 3.00am, the later time referencing when she had been found following the fall. That time is consistent with the RACF records. I prefer the records of the RACF as providing an accurate record of the time and circumstances of Mrs Martin’s fall and find accordingly that the fall occurred at around 3.00am.

From the time that AT were called to attend to Mrs Martin at the RACF there was a 3-hour and 47-minute delay. The call was first triaged as a Priority 2 Patient, but because Mrs Martin was in the care of nursing staff, the call was recategorised by AT as a Priority 3 Patient at 3.38am. It has been confirmed by AT that the categorisation of Mrs Martin’s priority was conducted in accordance with the International Academies of Emergency Dispatch Medical Priority Dispatch System (MPDS). In addition, AT reports that on the morning of Mrs Martin’s fall, they were experiencing a significant regional workload with surge escalation (Level 3 triggered at 3.06am), staffing shortages within the southern region, transfer of care delays at RHH and several crews entering a Priority 0 meal break window, reducing their capacity to respond to cases. These are the reasons given by them for the delay.

Comments and Recommendations

The circumstances of Mrs Martin's death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act 1995*.

I convey my sincere condolences to the family and loved ones of Mrs Martin.

Dated: 18 December 2024 at Hobart in the State of Tasmania.

Leigh Mackey
Coroner